RESTATEMENT OF THE LAW, LIABILITY INSURANCE

§ 1. Definitions

As used in this Restatement:

(1) A "condition" in a liability insurance policy is an event under the control of an insured, policyholder, or insurer that, unless excused, is required to occur, or not to have occurred, before performance becomes due under the policy.

(2) A "deductible" is the amount specified in a liability insurance policy by which coverage under the policy is reduced after the coverage amount is finally determined for the claim or claims to which the deductible applies. Unless otherwise stated in the insurance policy, none of the insurer's duties with respect to defense or indemnification are contingent upon the insured's payment of the deductible.

(3) An "exclusion" is a term in an insurance policy that identifies a category of claims that is not covered by the policy.

(4) An "insured" is a person with a right to coverage under an insurance policy.

(5) An "insuring clause" is a term in an insurance policy that grants insurance coverage.

(6) A "legal action" is a demand for redress of the kind that fits within the usual framework of insured liabilities. The demand can be formal or informal, and includes demands made before formal legal actions are commenced. The liability insurance policy defines which legal actions are insured under that policy.

(7) "Liability insurance" is insurance that exclusively or primarily covers risks related to the liability of an insured to third parties, including the liability-insurance-coverage part of an insurance policy that includes other forms of coverage.

(8) A "mandatory rule" is a rule of contract law or insurance law that cannot be changed by agreement of the parties.

(9) A "non-mandatory rule," otherwise known as a "default rule," is a rule of contract law or insurance law that can be changed by agreement of the parties.

(10) A "policyholder" is the person that acquires an insurance policy. In the liability insurance context, the policyholder typically is an insured under the policy, but there often are other persons that also qualify as insureds.

(11) A "policy limit" is a term in an insurance policy that identifies the maximum amount that the insurer is obligated to pay under the policy for the claim or claims subject to the policy limit.

(12) A "self-insured retention" is the amount specified in a liability insurance policy that must be paid by or on behalf of the insured for a covered loss before coverage under the policy begins to apply for the claim or claims to which the self-insured retention applies. Unless otherwise stated in the insurance policy, an insurer has no duty to defend or indemnify the insured until the insured has paid any applicable self-insured retention.

(13) A "standard-form term" is a term that appears in, or is taken from, an insurance policy form (including an endorsement) that an insurer makes available for a non-predetermined number of transactions in the insurance market.

(14) An insurance policy "term" is a word or set of words in an insurance policy that perform a discrete function in the policy. In the context of this Restatement, "term" typically refers to the word or set of words whose meaning or application is at issue in determining the coverage that is available in relation to a legal action brought against an insured.

§ 2. Insurance Policy Interpretation

(1) Insurance policy interpretation is the process of determining the meaning of the terms of an insurance policy. Whether those terms as so interpreted are enforceable is determined by reference to other legal rules.

(2) Insurance policy interpretation is a question of law.

(3) Except as this Restatement or applicable law otherwise provides, the ordinary rules of contract interpretation apply to the interpretation of liability insurance policies.

§ 3. The Plain-Meaning Rule

(1) If an insurance policy term has a plain meaning when applied to the facts of the claim at issue, the term is interpreted according to that meaning.

(2) The plain meaning of an insurance policy term is the single meaning to which the language of the term is reasonably susceptible when applied to facts of the claim at issue in the context of the entire insurance policy.

(3) If a term does not have a plain meaning as defined in subsection (2), that term is ambiguous and is interpreted as specified in § 4.

Comment:

b. Generally accepted sources of plain meaning. Generally accepted external sources of meaning that courts consult when determining the plain meaning of an insurance policy term include: dictionaries, court decisions, statutes and regulations, and secondary legal authority such as treatises and law-review articles. Such external sources of meaning are not "extrinsic evidence" under any definition of that term. Rather, they are legal authorities that courts consult when determining the plain meaning of an insurance policy term, which is a legal question.

c. Custom, practice, and usage. Some courts that follow a plain-meaning rule also consider custom, practice, and usage when determining the plain meaning of insurance policies entered into between parties who can reasonably be expected to have transacted with knowledge of that custom, practice, or usage. When such sources of meaning can be discerned from public sources and with only limited discovery (such as through an affidavit of an expert in the trade or business, who is subject to deposition, but without the need for extensive document requests), this is the better approach. Informed insurance-market participants conduct their business in light of custom, practice, and usage in the insurance market and in the trade or business being insured. Like the external sources of meaning listed in Comment *b*, custom, practice, and usage inform the court's determination of the objective meaning of insurance policy terms in the relevant market, as distinguished from the specific or subjective intent of a particular party. Efforts to ensure that insurance policy terms are interpreted in a manner that is consistent with those sources of meaning promote certainty in the insurance market. Moreover, in jurisdictions in which the meaning of an ambiguous term is a question for the jury, consideration of custom, practice, and usage at the plain-meaning stage of the analysis can help the court resolve an apparent ambiguity and thereby allow the court to determine the meaning of the term on summary judgment.

Consideration of custom, practice, and usage at the plain-meaning stage does not open the door to extrinsic evidence such as drafting history, course of dealing, or precontractual negotiations. In that regard, it is important to note that the term "extrinsic evidence" does not include all sources of meaning that are external to the policy. The facts of the claim at issue are external to the policy, as are custom, practice, and usage. Yet, all courts that follow the plain-meaning rule permit consideration of claim facts and some of those courts also permit consideration of trade custom, practice, and usage when determining whether a term has a plain meaning and, if so, what that meaning is.

While courts do not generally conduct a cost-benefit analysis when considering whether to permit consideration of custom, practice, and usage at the plain-meaning stage of the analysis, the costs of considering these sources of meaning should generally be low because, by definition, a custom, practice, or usage will be widely known in the insurance market, or in the trade or business being insured, and, thus, capable of being documented and presented to the court without burdensome discovery. There should be no need to take discovery to discern, prima facie, the existence of a custom, practice, or usage. Each party should be knowledgeable of custom, practice, and usage in its own trade or business; insurers should have access to information outside of discovery regarding custom, practice, and usages in the trades or businesses that they insure; and insureds should have access outside of discovery to insurance brokers and others with knowledge of the insurance industry. Discovery necessary to impeach an opposing party's evidence is a matter that trial judges have the capacity to manage. Note that custom, practice, and usage may be used against only a party who can reasonably be charged with knowledge of that custom, practice, or usage. Thus, for example, if there is a special, insurance-trade understanding of a term, and if the policyholder is an organization that would reasonably be expected to be aware of that trade understanding, then the term should ordinarily be given that meaning.

Illustrations:

1. A stock exchange is sued by a class of retail investors for actions taken in connection with a troubled initial public offering. The exchange's errors-and-omissions (E&O) insurer agrees to pay for the defense. The exchange's directors' and officers' (D&O) insurer denies coverage based on a professional-services exclusion in the policy that excludes coverage for any claim "by or on behalf of a customer or client of the" exchange. After settlement of the class action, the exchange and its E&O carrier bring an action against the D&O insurer seeking to recover a share of the costs of defense and settlement of the claim, arguing that the exchange's customers are brokers-dealers, not retail investors. Finding that the custom and usage of the term "customers" in the securities markets demonstrates that retail investors are customers of a stock exchange, the court grants summary judgment for the D&O insurer.

2. A fuel-delivery company is sued when fuel oil leaks out of a truck while parked overnight. The company seeks coverage from its auto liability insurer, which regularly

insures fuel delivery companies and is familiar with custom and practice in that trade. The insurer denies coverage based on an exclusion for release of pollutants "being stored . . . upon the covered auto." The fuel-delivery company brings a breach-of-contract action, on the ground that it had purchased a pollution liability endorsement that provided coverage for damages arising out of the release of pollutants "being transported" by covered vehicles or "otherwise in the course of transit by or on behalf" of the company. The fuel company demonstrates to the court that the established custom in the fuel-delivery business is to leave fuel in trucks while parked between deliveries, including overnight, and such activity is not regarded as storage in the truck. The court determines that fuel that is left in a truck while parked between deliveries overnight is "otherwise in the course of transit by" the company and grants summary judgment for the insured.

§ 4. Ambiguous Terms

(1) An insurance policy term is ambiguous if there is more than one meaning to which the language of the term is reasonably susceptible when applied to the facts of the claim at issue in the context of the entire insurance policy.

(2) When an insurance policy term is ambiguous as defined in subsection (1), the term is interpreted against the party that supplied the term, unless that party persuades the court that a reasonable person in the policyholder's position would not give the term that interpretation.

§ 5. Waiver

A party to an insurance policy waives a right under the policy if

(1) that party, with actual or constructive knowledge of the facts giving rise to that right, expressly relinquishes the right, or engages in conduct that would reasonably be regarded by the counterparty as an intentional relinquishment of that right, and

(2) the relinquishment or conduct is communicated or known to the counterparty.

§ 6. Estoppel

A party to an insurance policy who makes a promise or representation that can reasonably be expected to induce detrimental reliance by another party to the policy is

estopped from denying the promise or representation if the other party does in fact reasonably and detrimentally rely on that promise or representation.

§ 7. Misrepresentation

(1) Any statement of fact made by a policyholder in an application for an insurance policy is a representation by the policyholder.

(2) Subject to the rules governing defense obligations, an insurer may deny a claim or rescind the applicable insurance policy on the basis of an incorrect representation made by a policyholder in an application for an insurance policy (hereinafter referred to as a misrepresentation) only if the following requirements are met:

(a) The misrepresentation was material as defined in § 8; and

(b) The insurer reasonably relied on the misrepresentation in issuing or renewing the policy as specified in § 9.

(3) When the policy is rescinded under subsection (2), the insurer must return all of the premiums paid for the policy.

§ 8. Materiality Requirement

A misrepresentation by an insured during the application for, or renewal of, an insurance policy is material only if, but for the misrepresentation, a reasonable insurer in this insurer's position would not have issued the policy or would have issued the policy only under substantially different terms.

§ 9. Reasonable-Reliance Requirement

The reliance requirement of § 7(2)(b) is met only if:

(1) But for the misrepresentation, the insurer would not have issued the policy or would have issued the policy only with substantially different terms; and

(2) Such actions would have been reasonable under the circumstances.

§ 10. Scope of the Right to Defend

When a liability insurance policy grants the insurer the right to defend a legal action, that right includes, unless otherwise stated in the policy or limited by applicable law:

(1) The authority to direct all the activities of the defense of any legal action that the insurer has a right to defend, including the selection and oversight of defense counsel; and

(2) The right to receive from defense counsel all information relevant to the defense or settlement of the action, subject to the exception for confidential information stated in § 11(2).

§ 11. Confidentiality

(1) An insurer or insured does not waive rights of confidentiality with respect to third parties by providing to the insured or the insurer, within the context of the investigation and defense of a legal action, information protected by attorney–client privilege, work-product immunity, or other confidentiality protections.

(2) An insurer does not have the right to receive any information of the insured that is protected by attorney–client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured.

§ 12. Liability of Insurer for Conduct of Defense

(1) If an insurer undertakes to select counsel to defend a legal action against the insured and fails to take reasonable care in so doing, the insurer is subject to liability for the harm caused by any subsequent negligent act or omission of the selected counsel that is within the scope of the risk that made the selection of counsel unreasonable.

(2) An insurer is subject to liability for the harm caused by the negligent act or omission of counsel provided by the insurer to defend a legal action when the insurer directs the conduct of the counsel with respect to the negligent act or omission in a manner that overrides the duty of the counsel to exercise independent professional judgment.

§ 13. Conditions Under Which the Insurer Must Defend

(1) An insurer that has issued an insurance policy that includes a duty to defend must defend any legal action brought against an insured that is based in whole or in part on any allegations that, if proved, would be covered by the policy, without regard to the merits of those allegations.

(2) For the purpose of determining whether an insurer must defend, the legal action is deemed to be based on:

(a) Any allegation contained in the complaint or comparable document stating the legal action; and

(b) Any additional allegation known to the insurer, not contained in the complaint or comparable document stating the legal action, that a reasonable insurer would regard as an actual or potential basis for all or part of the action.

(3) An insurer that has the duty to defend under subsections (1) and (2) must defend until its duty to defend is terminated under § 18 by declaratory judgment or otherwise, unless facts not at issue in the legal action for which coverage is sought and as to which there is no genuine dispute establish that:

(a) The defendant in the action is not an insured under the insurance policy pursuant to which the duty to defend is asserted;

(b) The vehicle or other property involved in the accident is not covered property under a liability insurance policy pursuant to which the duty to defend is asserted and the defendant is not otherwise entitled to a defense;

(c) The claim was reported late under a claims-made-and-reported policy such that the insurer's performance is excused under the rule stated in § 35(2);

(d) The action is subject to a prior-and-pending-litigation exclusion or a related-claim exclusion in a claims-made policy;

(e) There is no duty to defend because the insurance policy has been properly cancelled; or

(f) There is no duty to defend under a similar, narrowly defined exception to the complaint-allegation rule recognized by the courts in the applicable jurisdiction.

Comment:

c. Coverage questions that turn on facts not at issue in the legal action against the insured. The general rule is that insurers may not use facts outside the complaint as the basis for refusing to defend, with the result that even an insurer with a strong factual basis for contesting coverage must defend under a reservation of rights and then file a declaratory-judgment action to terminate the duty to defend. Only in a declaratory-judgment action filed while the insurer is defending, or in a coverage action that takes place after the insurer has fulfilled the duty to defend, may the insurer use facts outside the complaint as the basis for avoiding coverage. Courts that follow this general rule have identified the five specific exceptions to this rule stated in subsection (3). In these circumstances, courts have allowed insurers to refuse to defend even when the elements of the complaint-allegation rule are otherwise met.

Courts in a few states have recognized a broader, general exception to the complaint-allegation rule that allows insurers to refuse to defend based on their unilateral assessment of any facts that are not at issue in the legal action for which coverage is sought. Although this Section does not recognize this broader exception, a court following this Section could recognize other narrow exceptions on a case-by-case basis, reasoning by analogy to the exceptions stated in subsection (3). Each such case requires striking a balance between the benefits of judicial supervision of the decision to refuse to provide a defense and the benefits of avoiding the need for declaratory-judgment actions in cases in which undisputed facts, not at issue in the liability action for which coverage is sought, establish that a legal action is not covered.

Illustrations:

4. Homeowner is sued by Guest alleging injuries from a slip and fall. Homeowner's liability insurer refuses to defend on the ground that it has the right to rescind the policy because the Homeowner falsely answered "no" to a question regarding prior convictions on the application for the applicable insurance policy. The insurer has breached the duty to defend because the complaint alleges a covered cause of action and a misrepresentation defense is not one of the exceptions to the complaint-allegation rule listed in subsection (3).

5. Same facts as Illustration 4, except the insurer defends under a reservation of rights and files a declaratory-judgment action seeking to terminate the duty to defend. In that declaratory-judgment action, the insurer's duty to defend is determined based upon all the facts and circumstances including any information not included in the complaint that might show that the insurer is entitled to rescind the policy for misrepresentation.

6. Driver is sued by pedestrian alleging injuries from an automobile accident involving Sedan, which is owned by Driver's friend. Driver requests a defense from Insurer solely on the ground that Insurer issued a policy pursuant to which Sedan is a covered vehicle. Insurer denies coverage on the ground that Sedan is not a covered vehicle. Sedan is, in fact, not a covered vehicle under the policy. Accordingly, the insurer has not breached the duty to defend.

7. Law firm is sued by Client for malpractice. The law firm does not provide notice of the suit to the insurer on the risk until six months after the end of the applicable claims-made-and-reported insurance policy. The policy contains a condition in the insuring

agreement that requires the law firm to report the claim to the insurer no later than 120 days after the conclusion of the policy period. The insurer refuses to defend based on breach of the claim-reporting condition. The insurer did not breach the duty to defend because these are circumstances that qualify under the rule stated in § 35(2), pursuant to which the insurer need not prove prejudice in order to avoid coverage based on the insured's failure to meet the claim-reporting condition.

§ 14. Duty to Defend: Basic Obligations

When an insurance policy obligates an insurer to defend a legal action:

(1) Subject to the insurer's right to terminate the defense under § 18, the insurer has a duty to provide a defense of the action that:

(a) Makes reasonable efforts to defend the insured from all of the causes of action and remedies sought in the action, including those not covered by the liability insurance policy; and

(b) Requires defense counsel to protect from disclosure to the insurer any information of the insured that is protected by attorney–client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured;

(2) The insurer may fulfill the duty to defend using its own employees, except when an independent defense is required; and

(3) Unless otherwise stated in the policy, the costs of the defense of the action are borne by the insurer in addition to the policy limits.

§ 15. Reserving the Right to Contest Coverage

(1) An insurer may reserve the right to contest coverage for an action before undertaking the defense of the action if it gives timely notice to the insured of any ground for contesting coverage of which it knows or should know.

(2) If an insurer already defending a legal action learns of information, which it did not have constructive notice of under subsection (1), that provides a ground for contesting coverage for that action, the insurer must give notice of that ground to the insured within a reasonable time to reserve the right to contest coverage for the action on that ground.

(3) Notice to the insured of a ground for contesting coverage must include a written explanation of the ground, including the specific insurance policy terms and facts upon which the potential ground for contesting coverage is based, in language that is understandable by a reasonable person in the position of the insured.

(4) When an insurer reasonably cannot complete its investigation before undertaking the defense of a legal action, the insurer may temporarily reserve its right to contest coverage for the action by providing to the insured an initial, general notice of reservation of rights, in language that is understandable by a reasonable person in the position of the insured, but to preserve that reservation of rights the insurer must pursue that investigation with reasonable diligence and must provide the detailed notice stated in subsection (3) within a reasonable time.

§ 16. The Obligation to Provide an Independent Defense

When an insurer with the duty to defend provides the insured notice of a ground for contesting coverage under § 15 and there are facts at issue that are common to the legal action for which the defense is due and to the coverage dispute, such that the action could be defended in a manner that would benefit the insurer at the expense of the insured, the insurer must provide an independent defense of the action.

§ 17. The Conduct of an Independent Defense

When an independent defense is required under § 16:

(1) The insurer does not have the right to defend the legal action;

(2) The insured may select defense counsel and related service providers;

(3) The insurer is obligated to pay the reasonable fees of the defense counsel and related service providers on an ongoing basis in a timely manner;

(4) The insurer has the right to associate in the defense of the legal action under the rules stated in § 23; and

(5) The rules stated in § 11 govern the insured's provision of information to the insurer.

§ 18. Terminating the Duty to Defend a Legal Action

An insurer's duty to defend a legal action terminates only upon the occurrence of one or more of the following events:

(1) An explicit waiver by the insured of its right to a defense of the action;

(2) Final adjudication of the action;

(3) Final adjudication or dismissal of parts of the action that eliminates any basis for coverage of any remaining parts of the action;

(4) Settlement of the action that fully and finally resolves the entire action;

(5) Partial settlement of the action, entered into with the consent of the insured, that eliminates any basis for coverage of any remaining parts of the action;

(6) If so stated in the insurance policy, exhaustion of the applicable policy limits;

(7) A correct determination by the insurer that it does not have a duty to defend the legal action under the rules stated in § 13; or

(8) Final adjudication that the insurer does not have a duty to defend the action.

Comment:

i. Withdrawal pursuant to a correct determination that the insurer does not have a duty to defend under the rules stated in § 13. Subsection (7) to this Section is a corollary to § 13. Subsection (7) clarifies that an insurer has a continuing opportunity to reevaluate whether it has a duty to defend under the rules in § 13. An insurer that starts to defend an action is permitted to withdraw from the defense if it subsequently determines, correctly, that it does not have a duty to defend under the rules in § 13, for example because (a) the insurer has learned of facts to which there is no genuine dispute establishing that one of the § 13(3) exceptions to the complaint-allegation rule applies, (b) there has been a legal development in the jurisdiction resolving a previously undecided question of law, (c) the insurer determines for some other reason that it incorrectly applied the complaint-allegation rule in the first instance, or (d) the circumstances have clarified that there is no obligation to defend under the potentiality rule. Note that the insurer's determination regarding the duty to defend must be correct. An incorrect determination and withdrawal of a defense is a breach of the duty to defend.

§ 19. Consequences of Breach of the Duty to Defend

An insurer that breaches the duty to defend a legal action forfeits the right to assert any control over the defense or settlement of the action.

§ 20. When Multiple Insurers Have a Duty to Defend

When more than one insurer has the duty to defend a legal action brought against an insured:

(1) The insured may select any of these insurers to provide a defense of the action;

(2) If that insurer refuses to defend or otherwise breaches the duty to defend, the insured may select any of the other insurers that has a duty to defend the action; and

(3) The selected insurer must provide a full defense until the duty to defend is terminated pursuant to § 18 or until another insurer assumes the defense pursuant to subsection (4)(a).

(4) If the policies establish an order of priority of defense obligations among them, or if there is a regular practice in the relevant insurance market that establishes such a priority, that priority will be given effect as follows:

(a) An insurer selected pursuant to subsection (1) or (2) may ask any insurer whose duty to defend is earlier in the order of priority to assume the defense; and

(b) An insurer that incurs defense costs has a right of contribution or indemnity for those costs against any other insurer whose duty to defend is in the same position or earlier in the order of priority.

(5) If neither the policies nor the insurance-market practice establish an order of priority:

(a) The duty to defend is independently and concurrently owed to the insured by each of the insurers;

(b) Any nonselected insurer has the obligation to pay its pro rata share of the reasonable costs of defense of the action and the noncollectible shares of other insurers; and

(c) A selected insurer may seek contribution from any of the other insurers for the costs of defense.

§ 21. Insurer Recoupment of the Costs of Defense

Unless otherwise stated in the insurance policy or otherwise agreed to by the insured, an insurer may not seek recoupment of defense costs from the insured, even when it is subsequently determined that the insurer did not have a duty to defend or pay defense costs.

§ 22. Defense-Cost-Indemnification Policies

(1) A defense-cost-indemnification policy is an insurance policy in which the insurer agrees to pay the costs of defense of a covered legal action and does not undertake the duty to defend. Typically, such policies also cover settlements and judgments.

(2) When a defense-cost-indemnification policy obligates an insurer to pay the costs of defense on an ongoing basis:

(a) The scope of the insurer's defense-cost obligation is determined using the rules governing the duty to defend stated in § 13, § 18, and § 20;

(b) To preserve the right to contest coverage for a legal action, the insurer must follow the reservation-of-rights procedure stated in § 15; and

(c) An insurer that breaches this defense-cost obligation loses the right to associate in the defense of the action under § 23 and the right to exercise any control in the settlement of the action.

(3) When a defense-cost-indemnification policy does not obligate an insurer to pay the costs of defense of a covered legal action on an ongoing basis, the insurer's obligation to pay defense costs is determined based on all the facts and circumstances, unless otherwise provided in the policy.

§ 23. The Right to Associate in the Defense

(1) When an insurer has the right to associate in the defense of a legal action, that right includes, unless otherwise stated in the insurance policy:

(a) The right to receive from defense counsel and the insured, upon request, information that is reasonably necessary to assess the insured's potential liability and to determine whether the defense is being conducted in a manner that is commensurate with that potential liability, with the exception of information

protected by attorney–client privilege, work-product immunity, or a defense lawyer's duty of confidentiality under rules of professional conduct, if that information could be used to benefit the insurer at the expense of the insured; and

(b) A reasonable opportunity to be consulted regarding major decisions in the defense of the action that is consistent with the insurer's level of engagement with the defense of the action.

(2) The provision of information to an insurer pursuant to the right to associate does not waive any confidentiality rights of the insured with respect to third parties.

§ 24. The Insurer's Duty to Make Reasonable Settlement Decisions

(1) When an insurer has the authority to settle a legal action brought against the insured, or the insurer's prior consent is required for any settlement by the insured to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.

(2) A reasonable settlement decision is one that would be made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment.

(3) An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.

Comment:

a. Relationship to the duty of good faith and fair dealing. Because of its origins in the duty of good faith and fair dealing, courts in many jurisdictions refer to the standard for breach of the duty to make reasonable settlement decisions as one of "bad faith." That formulation suggests the need to prove bad intent on the part of the insurer that goes beyond the reasonableness standard stated in this Section, and some courts do require such a showing. In most breach-of-settlement-duty cases, however, even those that invoke the language of bad faith, the ultimate test of liability is whether the insurer's conduct was reasonable under the circumstances.

This Restatement clarifies the law by making a clear distinction among several categories of insurance-law cases that many courts classify together as insurance bad-faith cases but in practice treat as distinct from each other. Two of these categories of cases deal with the settlement context; the third deals with contexts not involving settlement.

The first category is that of an insurer that allegedly made an unreasonable settlement decision that resulted in, or could result in, an excess verdict against the insured. This is the category of cases addressed in this Section. For this category of cases, courts generally apply an objective, commercial-reasonableness standard, as distinct from a standard that relies primarily on proof of bad intent. To make clear that an insurer's settlement duty is grounded in commercial reasonableness, this Section does not use the term "bad faith" to describe the insurer's breach of the duty to make reasonable settlement decisions. Rather, this Section states expressly the commercial-reasonableness standard that most courts actually apply.

The second category of cases that many courts classify as involving insurance bad faith is that of an insurer that allegedly engaged in improper conduct outside of the settlement context. For those cases, which are much less frequently the subject of published liability insurance opinions than breach-of-settlement-duty cases, this Restatement uses the term "bad faith" and, like most courts, applies a more demanding two-prong test, as stated in § 49. Separating these first two categories of cases clarifies and improves the law by reducing the likelihood that an inexperienced judge or lawyer will mistakenly conclude that the same legal standard applies in both categories.

The third category of cases that many courts classify as involving insurance bad faith is that of an insurer whose improper conduct in the settlement context goes beyond unreasonableness and satisfies the more demanding two-prong test stated in § 49. Under the rules as clarified in this Restatement, such an insurer would be subject to additional liability for bad faith under § 49. That additional liability can include attorneys' fees and, if the relevant state-law standard is met, punitive damages. See § 50. To be clear: a liability insurer that breaches the duty to make reasonable settlement decisions stated in this Section is subject to liability for damages under § 27, but it is not thereby subject to liability for insurance bad faith unless the insured proves that the insurer's conduct also meets the more demanding requirements of § 49. See Comment *c* to § 49.

f. The insurer's failure to make settlement offers and counteroffers. This Section adopts a reasonableness standard, not a hard-and-fast rule regarding the insurer's obligation to make settlement offers or counteroffers. As with an insurer's settlement decisions generally, the question is what a reasonable insurer would do under the circumstances. In the absence of a reasonable offer by the plaintiff, there can be circumstances in which it would be unreasonable for an insurer not to make a settlement offer before trial, such as, for example, when the facts known to the insurer make clear that the policy limits are significantly less than the reasonable settlement value of the

underlying case (perhaps because the claimant's damages are indisputable and very large and the likelihood of the insured's being found liable is high). In such circumstances, the insurer's obligation to attempt to protect its insured from an excess judgment may include making a reasonable settlement offer to the claimant. By making such an offer, and by otherwise behaving reasonably in the settlement negotiations, the insurer can eliminate its potential liability for an excess judgment, even if that offer is rejected. It is important to emphasize, however, that there may be good reasons for an insurer not to make an offer. For example, it may be strategically useful, from the perspective of a reasonable insurer that bears the full risk of judgment, to refrain from making a settlement offer in order to gather more information, to encourage the claimant to reveal more about its case, or to place pressure on the claimant to initiate settlement discussions. Of course, the insurer's strategic reasons for not making a settlement offer must relate solely to the legal action at issue, not to the insurer's interest in managing its portfolio of legal actions. It should also be noted that an insurer has no obligation to make a settlement offer that exceeds the policy limits. However, in situations in which a reasonable insurer bearing sole responsibility for the entire judgment would make an above-limits offer, the insurer may have an obligation to invite the insured to contribute to an above-limits settlement offer.

§ 25. The Effect of a Reservation of Rights on Settlement Rights and Duties

(1) A reservation of the right to contest coverage does not relieve an insurer of the duty to make reasonable settlement decisions stated in § 24, but the insurer is not required to cover a judgment on a noncovered claim.

(2) Unless otherwise stated in an insurance policy or agreed to by the insured, an insurer may not settle a legal action and thereafter demand recoupment of the settlement amount from the insured on the ground that the action was not covered.

(3) When an insurer has reserved the right to contest coverage for a legal action, the insured may settle the action without the insurer's consent and without violating the duty to cooperate or other restrictions on the insured's settlement rights contained in the policy if:

(a) The insurer receives all information reasonably necessary to evaluate the legal action and has a reasonable amount of time to do so;

(b) The insurer is given a reasonable opportunity to participate, and is kept reasonably informed of developments, in the settlement process;

(c) The insured makes a reasonable effort to obtain the insurer's consent or approval of the settlement, including by providing the insurer with a reasonable amount of time to evaluate all the terms of the settlement agreement;

(d) The insurer declines to withdraw its reservation of rights after receiving prior notice of the proposed settlement; and

(e) The settlement agreed to by the insured is one that a reasonable person who bears the sole financial responsibility for the full amount of the potential covered judgment would make.

Comment:

e. Settlements by the insured prior to coverage determination. In circumstances in which an insurer that has not accepted coverage refuses to withdraw either its coverage contest or its control over settlement, courts have reached different conclusions about whether an insured may protect its interests by accepting a settlement within the limits of the policy. While perhaps not yet the majority rule, an increasingly large number of states permit the insured to settle without the consent of the insurer even if the policy contains a provision requiring consent. Subsection (3) follows this emerging rule while adding some procedural requirements designed to protect against collusive or improvident settlements. This rule allows the insured to protect itself against the risk of a large, uncovered verdict while preserving the insurer's right to contest both coverage and the reasonableness of the settlement. The insurer's liability for such settlements is subject to the policy limits, as well as any potential grounds for contesting coverage. The rule in subsection (3) does not authorize the insured to enter into a settlement or consent judgment in excess of the policy limits that obligates the insurer to pay for the amount by which that settlement or consent judgment exceeds the policy limits.

The effect of the rule is to give an insurer that is disputing coverage for a legal action the choice between (a) accepting the coverage obligation and retaining control of the defense and the settlement of the legal action or (b) preserving the right to contest coverage and permitting the insured to make a reasonable settlement of the legal action. The rule encourages insurers to drop a weak ground for contesting coverage in order to maintain control over settlement of the legal action because it is primarily the insurer's money at stake in that action when its grounds for contesting coverage are weak. The rule encourages insurers with strong grounds for contesting coverage to grant control over settlement to the insured. Granting the insured control over settlement in such

cases is appropriate: because of the strong grounds for contesting coverage, it is primarily the insured's money at stake.

Because of the potential for collusion, all such settlements should be scrutinized to ensure that they are reasonable both in substance and procedure. In addition to interrogating the reasonableness of the terms of the settlement, courts should ask questions such as the following: (1) Did the insurer receive all information reasonably necessary to evaluate the legal action? (2) Did the insurer have a reasonable opportunity to participate in the settlement process? (3) Did the insurer have a reasonable amount of time to evaluate the legal action and all the terms of any proposed settlement agreement? (4) Were any reservations regarding the terms of the settlement expressed by the insurer fully and fairly communicated to the insured? (5) Was the insurer informed of material developments in the settlement process? (6) Are there any indicia of collusion between the insured and the underlying claimant in the settlement process?

Illustration:

2. A claimant files a tort suit against the insured seeking damages of $500,000. The insured has a duty-to-defend liability insurance policy with policy limits of $100,000 and that assigns settlement discretion to the insurer. The insured tenders the defense of the suit to the insurer, which agrees to defend under a reservation of rights. As the case approaches trial, the claimant makes a settlement demand of $100,000. The insurer rejects the settlement demand, preferring to negotiate for a lower settlement or to take the case to trial. The insured, however, believes that the settlement demand should be accepted. The insured notifies the insurer that she is in settlement negotiations with the claimant. The insurer declines to participate or to withdraw its coverage contest. The insured enters into a settlement with the claimant for $100,000. The insured may bring a breach-of-contract action against the insurer to recover the amount of the settlement or, if the claimant is willing to wait, to require the insurer to pay the settlement. In the breach-of-contract action, the insurer's coverage contest will be resolved on the basis of all of the facts and circumstances, because the insurer did not breach the duty to defend.

§ 26. The Effect of Multiple Claimants on the Duty to Make Reasonable Settlement Decisions

(1) If multiple legal actions that would count toward a single policy limit are brought against an insured, the insurer has a duty to the insured to make a good-faith effort to settle the actions in a manner that minimizes the insured's overall exposure.

(2) The insurer may, but need not, satisfy this duty by interpleading the policy limits to the court, naming all known claimants, and, if the insurer has a duty to defend or a duty to pay defense costs on an ongoing basis, continuing to defend or pay the defense costs of its insured until:

(a) Settlement of the legal actions;

(b) Final adjudication of the actions; or

(c) Adjudication that the insurer does not have a duty to defend or to pay the defense costs of the actions.

§ 27. Damages for Breach of the Duty to Make Reasonable Settlement Decisions

(1) An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for any foreseeable harm caused by the breach, including the full amount of damages assessed against the insured in the underlying legal action, without regard to the policy limits.

(2) When an insurer has breached the duty to make reasonable settlement decisions, the insured may settle the action without the insurer's consent and without violating the duty to cooperate or other restrictions on the insured's settlement rights contained in the policy if:

(a) The insurer receives all information reasonably necessary to evaluate the legal action and has a reasonable amount of time to do so;

(b) The insurer is given a reasonable opportunity to participate, and is kept reasonably informed of developments, in the settlement process;

(c) The insured makes a reasonable effort to obtain the insurer's consent or approval of the settlement, including by providing the insurer with a reasonable amount of time to evaluate all the terms of the settlement agreement; and

(d) The settlement agreed to by the insured is one that a reasonable person who bears the sole financial responsibility for the full amount of the potential covered judgment would make.

Comment:

e. When the underlying suit results in punitive damages. If a liability insurer's unreasonable failure to settle a legal action against the policyholder results in a compensatory-damages award in excess of the policy limits and a punitive-damages award against the policyholder in that action, the amount of that punitive-damages award is included in the consequential damages owed for breach of the insurer's duty. This rule is unproblematic in most jurisdictions, because a punitive-damages award is a foreseeable consequence of the insurer's breach and the majority rule permits insurance for punitive damages.

In jurisdictions in which insurance for punitive damages is contrary to public policy, however, there is tension between a rule forbidding the sale of liability insurance against punitive damages and a rule that requires an insurer to indemnify the insured for such damages when the insurer has breached the duty to make reasonable settlement decisions. Although most courts have not addressed this issue, the very few state courts that have addressed it have resolved the tension in favor of the public policy against insurance for punitive damages, typically in divided judgments with strong dissents indicating that there is considerable uncertainty regarding the direction insurance law should take. This Section follows the approach of the dissenting judges in those cases for several reasons. First, this approach furthers the public policy in favor of encouraging reasonable settlement decisions by insurers. Second, the contrary approach would create a conflict of interest in the defense of the claim that would increase the frequency of cases in which independent counsel would be required under § 16. See § 16, Comment *d*. Third, the incentive argument in favor of the contrary approach is implausible.

Illustration:

7. Insured has a duty-to-defend liability insurance policy with policy limits of $1 million. A claim is brought against the insured seeking $5 million in compensatory damages and $3 million in punitive damages. The liability insurance policy excludes punitive damages from coverage. Moreover, the relevant state law provides that insurance coverage for punitive damages is a violation of public policy. However, it was reasonably

foreseeable at the time of contracting that, if the insured loses this kind of suit, she will be liable for both compensatory and punitive damages. As the trial approaches, the claimant makes a settlement demand equal to the value of the policy limits. According to the evidence available to the insurer at the time of the settlement negotiations, this demand was reasonable in light of the expected compensatory damages, alone, because there was a high likelihood of liability at trial. The insurer nevertheless rejects the demand and takes the case to trial, which results in a verdict against the insured for $5 million of compensatory damages and $3 million of punitive damages. The insurer is liable for the full amount of the excess judgment ($7 million).

§ 28. Excess Insurer's Right of Subrogation

An excess insurer has an equitable right of subrogation for loss incurred as a result of an underlying insurer's breach of the duty to make reasonable settlement decisions.

§ 29. The Insured's Duty to Cooperate

When an insured seeks liability insurance coverage from an insurer, the insured has a duty to cooperate with the insurer. The duty to cooperate includes the obligation to provide reasonable assistance to the insurer:

(1) In the investigation and settlement of the legal action for which the insured seeks coverage;

(2) If the insurer is providing a defense, in the insurer's defense of the action; and

(3) If the insurer has the right to associate in the defense of the action, in the insurer's exercise of the right to associate.

§ 30. Consequences of the Breach of the Duty to Cooperate

(1) An insured's breach of the duty to cooperate relieves an insurer of its obligations under an insurance policy only if the insurer demonstrates that the failure caused or will cause prejudice to the insurer.

(2) If an insured's collusion with a claimant is discovered before prejudice has occurred, the prejudice requirement is satisfied if the insurer demonstrates that the collusion would have caused prejudice to the insurer had it not been discovered.

§ 31. Insuring Clauses

(1) An "insuring clause" is a term in a liability insurance policy that grants insurance coverage.

(2) Whether a term in a liability insurance policy is an insuring clause does not depend on where the term is in the policy or the label associated with the term in the policy.

(3) Insuring clauses are interpreted broadly.

§ 32. Exclusions

(1) An "exclusion" is a term in an insurance policy that identifies a category of claims that are not covered by the policy.

(2) Whether a term in an insurance policy is an exclusion does not depend on where the term is in the policy or the label associated with the term in the policy.

(3) Exclusions are interpreted narrowly.

(4) Unless otherwise stated in the insurance policy, words in an exclusion regarding the expectation or intent of the insured refer to the subjective state of mind of the insured.

(5) An exception to an exclusion narrows the application of the exclusion; the exception does not grant coverage beyond that provided in the insuring clauses.

§ 33. Timing of Events That Trigger Coverage

(1) When a liability insurance policy provides coverage based on the timing of a harm, event, wrong, loss, activity, occurrence, claim, or other happening, the determination of the timing is a question of fact.

(2) A liability insurance policy may define a harm, event, wrong, loss, activity, occurrence, claim, or other happening that triggers coverage under a liability insurance policy to have taken place at a specially defined time, the timing of which is also a question of fact, even if it would be determined for other purposes to have taken place at a different time.

§ 34. Conditions in Liability Insurance Policies

(1) A "condition" in a liability insurance policy is an event under the control of an insured, policyholder, or insurer that, unless excused, must occur, or must not occur, before performance under the policy becomes due under the policy.

(2) Whether a term in a liability insurance policy is a condition does not depend on where the term is in the policy or the label associated with the term in the policy.

(3) The failure of an insured to satisfy cooperation conditions, under the rules stated in § 30, and notice-of-claim conditions, under the rules stated in § 35(1), does not relieve the insurer of its obligations under the policy unless the failure caused prejudice to the insurer.

§ 35. Notice and Reporting Conditions

(1) Except as stated in subsection (2), the failure of the insured to satisfy a notice-of-claim condition excuses an insurer from performance of its obligations under a liability insurance policy only if the insurer demonstrates that it was prejudiced by the failure.

(2) With respect to claims first reported after the conclusion of the claim-reporting period in a claims-made-and-reported policy, the failure of the insured to satisfy the claim-reporting condition in the policy excuses an insurer from performance under the policy without regard to prejudice, except when:

(a) The policy does not contain an extended reporting period;

(b) The claim at issue is made too close to the end of the policy period to allow the insured a reasonable time to satisfy the condition; and

(c) The insured reports the claim to the insurer within a reasonable time.

Comment:

f. An extended reporting period. To avoid the forfeiture that would otherwise result in circumstances in which a claim is made too close to the end of the policy period to allow the policyholder sufficient time to report the claim to the insurer, contemporary claims-made-and-reported policies commonly provide for an additional period of time, after the end of the policy period, during which the insured may report a claim that was first made during the policy period. This additional period of time is generally referred to as an "extended reporting period." Typically, claims-made-and-reported policies include an extended reporting period of at least 60 days, often longer. Some states have statutes that mandate the inclusion of an extended reporting period in certain policies. When a claims-made-and-reported policy includes an extended reporting period, subsection (2)'s narrow exception to the general rule regarding strict enforcement of the claim-reporting condition does not apply.

g. When the policy does not contain an extended reporting period. Published opinions rarely address the situation in which an insured did not have a reasonable time in which to report

a claim. Most published opinions that strictly enforce claims-reporting conditions in claims-made-and-reported policies involve claims in which the policy contained an extended reporting period or the insured reported the claim unreasonably long after the end of the policy period. Published opinions often describe claims that are reported over a year after the policy period ended, and there are few published opinions, especially in recent years, that involve claims that are reported less than three months after the end of the policy period. This is likely the result of the fact that most insurers wisely choose not to press to judgment denials of coverage that are based on claim-reporting requirements that an insured could not reasonably comply with in the circumstances. Among the few published opinions to address this situation, the majority strictly enforce the claim-reporting condition, but there is recent authority concluding that the loss of coverage due to the failure of the insurer to provide the insured with a reasonable time to report the claim in the circumstances is a disproportionate forfeiture. That is the source of the exception stated in subsection (2).

Relaxing the requirement that a claim must be reported during the policy period, by requiring that the insured must have had a reasonable time to satisfy the condition, does not pose a material increase in risk to the insurer. An insurer that grants the insured a reasonable time to report a claim receives all the legitimate benefits of strict enforcement of a claim-reporting condition that is included in the insuring agreement of a claims-made policy. While there are undoubted benefits to prompt reporting, the modest delay needed to allow the insured a reasonable time to report a claim should rarely, if ever, harm the insurer. And, if the delay does harm the insurer, the ordinary prejudice rule would protect the insurer. The only additional benefit that an insurer receives when it fails to grant the insured a reasonable time to provide notice is an illegitimate one: cost savings attributable to nonpayment of claims that are forfeited by insureds because there was insufficient time to report those claims. Under the rule stated in this Section an insurer can achieve the desired certainty by including an extended reporting condition in the policy.

Note that subsection (2) contemplates that the presence of an extended reporting period will adequately protect the policyholder from a disproportionate forfeiture attributable to the policyholder's inability to satisfy the claim-reporting condition in a claims-made-and-reported policy. Were a claims-made-and-reported policy to have an extended reporting period that was too short to allow the policyholder to avoid a disproportionate forfeiture in a particular case, a court could apply the contract-law disproportionate-forfeiture doctrine to excuse the policyholder's

failure to satisfy the reporting condition. See Restatement Second, Contracts § 229 (Excuse of a Condition to Avoid Forfeiture).

§ 36. Assignment of Rights Under a Liability Insurance Policy

(1) Except as otherwise stated in this Section, rights under a liability insurance policy are subject to the ordinary rules regarding the assignment of contract rights.

(2) Rights of an insured under an insurance policy relating to a specific claim that has been made against the insured may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments.

(3) Rights of an insured under an insurance policy relating to a class of claims or potential claims may be assigned without regard to an anti-assignment condition or other term in the policy restricting such assignments, if the following requirements are met:

(a) The assignment accompanies the transfer of financial responsibility for the underlying liabilities insured under the policy as part of a sale of corporate assets or similar transaction;

(b) The assignment takes place after the end of the policy period; and

(c) The assignment of the rights does not materially increase the risk borne by the insurer.

§ 37. Policy Limits

(1) A policy limit is a term in an insurance policy that identifies the maximum amount the insurer is obligated to pay under the policy for the claim or claims to which the policy limit applies.

(2) A per-occurrence, per-accident, per-claim, per-person, or other per-circumstance policy limit identifies the maximum amount the insurer is obligated to pay under the policy for a single occurrence, accident, claim, person, or other specified circumstance.

(3) An aggregate policy limit identifies the maximum amount the insurer is obligated to pay under the policy for a specified set of circumstances, regardless of the number of occurrences, accidents, claims, persons, or other specified circumstances. An insurance policy may have an aggregate limit that applies to all claims covered by the policy or it may have one or more aggregate limits that apply only to a defined set of claims. Not all liability insurance policies contain an aggregate limit.

§ 38. Number of Accidents or Occurrences

For liability insurance policies that have per-accident or per-occurrence policy limits, retentions, or deductibles, all bodily injury, property damage, or other harm caused by the same act or event constitutes a single accident or occurrence.

§ 39. Excess Insurance: Exhaustion and Drop Down

When an insured is covered by an insurance policy that provides coverage that is excess to an underlying insurance policy, the following rules apply, unless otherwise stated in the excess insurance policy:

(1) The excess insurer is not obligated to provide benefits under its policy until the underlying policy is exhausted;

(2) The underlying policy is exhausted when an amount equal to the limit of that policy has been paid to claimants for a covered loss, or for other covered benefits subject to that limit, by or on behalf of the underlying insurer or the insured; and

(3) If the underlying insurer is unable to perform, whether because of insolvency or otherwise, the excess insurer is not obligated to provide coverage in the place of the underlying insurer.

§ 40. Indemnification from Multiple Policies: The General Rule

(1) When more than one insurance policy provides coverage to an insured for a legal action, the insurers are independently and concurrently liable under their policies, subject to the limits of each policy, except as otherwise provided in subsection (2) and § 41.

(2) An insurance policy term that alters the default rule stated in subsection (1) will be given effect, except to the extent that the term cannot be harmonized with another policy and provided that the insured is not required to bear more of the costs of the claim than the insured would have borne under the applicable policy that is most favorable to the insured in this regard.

(3) When more than one insurer has a duty to defend an insured, the insurers' defense obligations are governed by § 20.

§ 41. Allocation in Long-Tail Harm Claims Covered by Occurrence-Based Policies

(1) Except as stated in subsection (2), when indivisible harm occurs over multiple policy periods, the amount of any judgment entered in or settlement of any liability action

arising out of that harm is subject to pro rata allocation under occurrence-based liability insurance policies as follows:

(a) For purposes of determining the share allocated to an occurrence-based liability insurance policy that is triggered by harm during the policy period, the amount of the judgment or settlement is allocated equally across years, beginning with the first year in which the harm occurred and ending with the last year in which the harm would trigger an occurrence-based liability insurance policy; and

(b) An insurer's obligation to pay for that pro rata share is subject to the ordinary rules governing any deductible, self-insured retention, policy limit, or exhaustion terms in the policy.

(2) When an insurance policy contains a term that alters the default rule stated in subsection (1), that term will be given effect, except to the extent that the term cannot be harmonized with an allocation term in another policy that provides coverage for the claim.

(3) Defense obligations relating to multiple triggered policies are subject to the rules in § 20.

§ 42. Contribution

(1) An insurer that indemnifies an insured for a legal action has a right of contribution against any other insurer with an indemnification obligation to that insured for that action to the extent that:

(a) The first insurer has paid more than its share of the costs;

(b) The other insurer has not settled with and been released by the insured; and

(c) The other insurer has paid less than its share of the costs.

(2) In determining the insurers' share of the costs, principles of restitution and unjust enrichment apply, subject to any allocation terms contained in the liability insurance policies at issue that are consistent with each other.

§ 43. The Effect of Partial Settlements on Amounts Owed by Non-Settling Insurers

In determining the declaration of rights and amount of any judgment to be entered against a liability insurer with respect to the insurer's obligation to provide coverage for a legal action brought against an insured, the amount of the insured's losses that are the

subject of the declaration or judgment is reduced by the amount paid for those losses by any insurers that settled with and were released by the insured with respect to that legal action.

§ 44. Implied-in-Law Terms and Restrictions

(1) A term that is required by law to be included in a liability insurance policy is so included by operation of law notwithstanding its absence in the written policy.

(2) A liability-insurance-policy term is unenforceable if:

(a) legislation prohibits enforcement, or

(b) the interest in its enforcement is clearly outweighed in the circumstances by a public policy against enforcement.

§ 45. Insurance of Liabilities Involving Aggravated Fault

(1) Except as barred by legislation or judicially declared public policy, a term in a liability insurance policy providing coverage for defense costs incurred in connection with any legal action is enforceable, including but not limited to defense costs incurred in connection with: a criminal prosecution; an action seeking fines, penalties, or punitive damages; and an action alleging criminal acts, expected or intentionally caused harm, fraud, or other conduct involving aggravated fault.

(2) Except as barred by legislation or judicially declared public policy, a term in a liability insurance policy providing coverage for civil liability arising out of aggravated fault is enforceable, including civil liability for: criminal acts, expected or intentionally caused harm, fraud, or other conduct involving aggravated fault.

(3) Whether a term in a liability insurance policy provides coverage for the defense costs and civil liability addressed in subsections (1) and (2) is a question of interpretation governed by the ordinary rules of insurance policy interpretation.

§ 46. Insurance of Known Liabilities

(1) Unless otherwise stated in the policy, a liability insurance policy provides coverage for a known liability only if that liability is disclosed to the insurer during the application or renewal process for the policy.

(2) For purposes of the rule stated in subsection (1), a liability is known when, prior to the inception of the policy period, the policyholder knows that, absent a settlement, an

adverse judgment establishing the liability in an amount that would exceed the amount of any applicable deductible or self-insured retention in the policy is substantially certain.

§ 47. Remedies Potentially Available

An action seeking determination of the rights of the parties to a liability insurance policy may be brought by either the insurer or the insured. In such an action, the remedies that may be available include:

(1) A declaration of the rights of the parties;

(2) An award of damages under § 48;

(3) Court costs or attorneys' fees to a prevailing party when provided by state law or the policy;

(4) If so provided in the liability insurance policy or otherwise agreed by the parties, an award of a sum of money due to the insurer as recoupment of the costs of defense or settlement;

(5) Collection and disbursement of interpleaded policy proceeds;

(6) Payment or return of premiums;

(7) Indemnification of the insurer by the insured when state law permits recovery from highly culpable insureds; and

(8) Prejudgment interest.

§ 48. Damages for Breach of a Liability Insurance Policy

The damages that an insured may recover for breach of a liability insurance policy include:

(1) In the case of a policy that provides defense coverage, all reasonable costs of the defense of a potentially covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

(2) All amounts required to indemnify the insured for a covered legal action that have not already been paid by the insurer, subject to any applicable limit, deductible, or self-insured retention of the policy;

(3) In the case of a breach of the duty to make reasonable settlement decisions, the damages stated in § 27; and

(4) Any other loss, including incidental or consequential loss, caused by the breach, provided that the loss was foreseeable by the insurer at the time of contracting as a probable result of a breach, which sums are not subject to any limit of the policy.

§ 49. Liability for Insurance Bad Faith

An insurer is subject to liability to the insured for insurance bad faith when it fails to perform under a liability insurance policy:

(a) Without a reasonable basis for its conduct; and

(b) With knowledge of its obligation to perform or in reckless disregard of whether it had an obligation to perform.

§ 50. Remedies for Liability Insurance Bad Faith

The remedies for liability insurance bad faith include:

(1) Compensatory damages, including the reasonable attorneys' fees and other costs incurred by the insured in the legal action establishing the insurer's breach of the liability insurance policy and any other loss to the insured proximately caused by the insurer's bad-faith conduct;

(2) Other remedies as justice requires; and

(3) Punitive damages when the insurer's conduct meets the applicable state-law standard.

Comment:

c. Other remedies as justice requires. The remedies for liability insurance bad faith generally are limited to the damages that the insured proves were caused by the insurer's bad-faith breach (including attorneys' fees) and, if the applicable state-law standard is met, punitive damages. There are some circumstances, however, in which courts have held that an insurer is estopped by its bad-faith conduct from asserting a coverage defense that it would have been able to assert had it fulfilled its contractual obligations. These circumstances have included: refusing to defend in bad faith, using the insured's defense counsel to collect information to support a denial of coverage, and denying the existence of a liability insurance policy. The common thread among these cases is a strong claim of misconduct in circumstances in which it would otherwise be difficult for the insured to demonstrate significant compensatory damages, thereby undercutting the deterrent effect of a bad-faith finding.

The loss-of-coverage-defense remedy is particularly appropriate when an insurer refuses to defend in bad faith. Requiring the insurer to pay for a judgment or settlement entered in such a case reinforces the importance of the defense coverage provided by traditional liability insurance policies, which promise to pay for the defense of any potentially covered claim and, in most cases, also to select the defense lawyer and manage the defense. An insurer that could abandon the defense whenever it concluded that the coverage-relevant facts were in its favor, without any risk of having to pay a judgment or settlement of the action, would have an incentive to do so. Thus, this remedy is structurally related to the remedy for breach of the duty to make reasonable settlement decisions, which addresses a similar misalignment of incentives in the settlement context. Both remedies align the insurer's incentives to be consistent with those of the insured, by providing a reason for the insurer to take into account all of the potential loss to the insured when making a crucial decision. The rule in § 27 encourages an insurer to evaluate a settlement offer as if it faced the full liability for the liability action, because the insurer will be liable under that rule for the full judgment entered in the action if a reasonable insurer would have accepted the offer. Similarly, requiring an insurer to provide coverage for a legal action that it refused in bad faith to defend encourages an insurer to evaluate the decision to defend as if it faced full liability for the action, because the insurer could be obligated to pay the judgment or settlement in the action if it refuses to defend in bad faith. This loss-of-coverage-defense remedy also draws support from (a) the rule followed in a respectable minority of states, pursuant to which an insurer that breaches the duty to defend *always* loses its coverage defenses, without regard to whether the insurer acted in bad faith or whether the available compensatory damages provide sufficient deterrence, and (b) the rule in § 15, pursuant to which an insurer that defends without a reservation of rights loses its coverage defenses. See Comment *a* to § 15.

